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Article

"*By slapping their laps, the patient will know that you truly care for her*": A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria

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ABSTRACT

Background: Many women experience mistreatment during childbirth in health facilities across the world. However, limited evidence exists on how social norms and attitudes of both women and providers influence mistreatment during childbirth. Contextually-specific evidence is needed to understand how normative factors affect how women are treated. This paper explores the acceptability of four scenarios of mistreatment during childbirth.

Methods: Two facilities were identified in Abuja, Nigeria. Qualitative methods (in-depth interviews (IDIs) and focus group discussions (FGDs)) were used with a purposive sample of women, midwives, doctors and administrators. Participants were presented with four scenarios of mistreatment during childbirth: slapping, verbal abuse, refusing to help the woman and physical restraint. Thematic analysis was used to synthesize findings, which were interpreted within the study context and an existing typology of mistreatment during childbirth.

Results: Eighty-four IDIs and 4 FGDs are included in this analysis. Participants reported witnessing and experiencing mistreatment during childbirth, including slapping, physical restraint to a delivery bed, shouting, intimidation, and threats of physical abuse or poor health outcomes. Some women and providers considered each of the four scenarios as mistreatment. Others viewed these scenarios as appropriate and acceptable measures to gain compliance from the woman and ensure a good outcome for the baby. Women and providers blamed a woman's "disobedience" and "uncooperativeness" during labor for her experience of mistreatment.

Conclusions: Blaming women for mistreatment parallels the intimate partner violence literature, demonstrating how traditional practices and low status of women potentiate gender inequality. These findings can be used to facilitate dialogue in Nigeria by engaging stakeholders to discuss how to

Abbreviations: ACASI, audio computer assisted self-interview; COREQ, consolidated criteria for reporting qualitative research; DHS, Demographic and Health Survey; FGD, focus group discussion; HRP, World Health Organization Human Reproduction Programme; IDI, in-depth interview; IPV, intimate partner violence; LMIC, low- and middle-income country; RP2, Review Panel on Research Projects; SDG, Sustainable Development Goals; USAID, United States Agency for International Development

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challenge these norms and hold providers accountable for their actions. Until women and their families are able to freely condemn poor quality care in facilities and providers are held accountable for their actions, there will be little incentive to foster change.

1. Background

A growing body of research suggests that many women experience mistreatment during childbirth in health facilities across the world (Bohren et al., 2015), including physical abuse (such as pinching or slapping) (Stop Making Excuses, 2011; McMahon et al., 2014; Moyer, Adongo, Aborigo, Hodgson, & Engmann, 2014), verbal abuse (Chadwick, Cooper, & Harries, 2014; D'Ambruoso, Abbey, & Hussein, 2005; Hatamleh, Shaban, & Homer, 2013) and discrimination by healthcare providers (Stop Making Excuses, 2011; Janevic, Sripad, Bradley, & Dimitrievska, 2011; Small, Yelland, Lumley, Brown, & Liamputtong, 2002). Mistreatment during childbirth can amount to a human rights violation, as all women have the right to respectful and dignified sexual and reproductive healthcare, including during childbirth (World Health Organization, 2014; Resolution 11/8, 2009; Technical guidance, 2012; UN General Assembly, 1948, 1976, 1993; White Ribbon Alliance, 2011). The importance of acknowledging and addressing this important area of women's health has gained traction since the publication of Bowser and Hill's (2010) report on disrespect and abuse during childbirth (Bowser & Hill, 2010). Most research has focused on descriptive qualitative analyses of experiences of mistreatment, with some small measurement studies (Kruk et al., 2014; Okafor, Ugwu, & Obi, 2015; Sando et al., 2014). Mistreatment during childbirth is a multi-dimensional issue, and prevention requires understanding the root causes that can include behavioral norms, professional ethics, facility environments and accountability mechanisms. To better understand how and why mistreatment during childbirth occurs, it is important to reflect on societal tolerance of violence and power dynamics.

1.1. Gender inequality, patient inferiority and violence against women

Jewkes, Abrahams & Mvo (1998) published findings from a qualitative study on why nurses abuse patients on South African maternity wards. The authors concluded that an "underpinning ideology of patient inferiority" was a primary driver of mistreatment, compounded by a complex relationship between "organizational issues, professional insecurities…[and the] perceived need to 'control' a woman's behavior" (Jewkes et al., 1998). Jewkes and Penn-Kekana (2015) draw a parallel between the typology of mistreatment during childbirth developed through a systematic review conducted by Bohren et al. (2015) and violence against women more broadly. They argue that violence against women in obstetric settings results from gender inequalities that place women in subordinate positions compared to men, thereby enabling the use of violence and promulgating disempowerment of women (Jewkes & Penn-Kekana, 2015).

Similarly, research evidence on attitudes towards intimate partner violence (IPV) suggests that IPV is often considered normal in the context of marital relationships, and is justifiable in different scenarios, such as if a woman refuses to have sex, or is perceived as neglecting children, committing infidelity or burning food (Hindin, 2003; Krishnan et al., 2012; Rani, Bonu, & Diop-Sidibe, 2004a; Uthman, Lawoko, & Moradi, 2009). Some research on mistreatment during childbirth suggests that providers and women may consider mistreatment to be justifiable, such as when women cry out or fail to comply with a provider's requests. Likewise, social norms around power dynamics and control influence both IPV and mistreatment during childbirth. As such, women in labor may be disempowered to speak out for their right to respectful care from healthcare providers, just as women are disempowered from standing up to abusive intimate partners. In low- and middle-income countries (LMICs), women often deliver at hospitals without birth companions who could advocate for their rights, and bear witness to occurrences of mistreatment. Furthermore, these facilities often lack accountability and redress mechanisms to address mistreatment that does occur. In these settings, healthcare providers may use their position (sometimes unintentionally or unknowingly) to exert power over and gain compliance from women, and women may have little choice but to submit to their demands.

1.2. Social norms and attitudes towards mistreatment during childbirth

Attitudes towards IPV are well documented in the literature (Hindin, 2003; Heise, Ellsberg, & Gottemoeller, 1999; Kim & Motsei, 2002; Koenig et al., 2003; National Population Commission (NPC) [Nigeria] & ICF International, 2014), and a set of questions has been incorporated into the Demographic and Health Survey (DHS) (Attitudes toward wife-beating). This work has demonstrated that where societies accept and tolerate violence against women, eradication is complex, as those perpetrating abuse may not recognize their actions as abusive (Rani, Bonu, & Diop-Sidibe, 2004b). Similarly, Freedman and Kruk argue that during childbirth, "practices that to the outside advocate or trained observer seem unambiguously disrespectful or abusive are often normalized" (Freedman & Kruk, 2014). Therefore, understanding how both women and providers perceive different acts that could be classified as mistreatment by an independent observer, researcher or advocate is a crucial step to be able to measure accurately and develop preventive measures (Vogel, Bohren, Tunçalp, Oladapo, & Gülmezoglu). However, limited research has been conducted globally on the influence of societal norms and attitudes towards the mistreatment of women during childbirth, and contextually-specific evidence is needed to understand how social and normative factors influence how women are treated during childbirth.

With growing recognition of the mistreatment of women during childbirth, there is a demonstrated need to better understand why it is occurring and to develop measurement tools to quantify the burden and contributing factors. As such, a two-phased, mixed-methods study is underway in Nigeria, Ghana, Guinea and Myanmar. In short, the first phase is a formative phase consisting of a multi-country primary qualitative study (Vogel et al., 2015). Findings from the formative phase will improve understanding of factors contributing to mistreatment during childbirth, identify potential entry points to reduce mistreatment, and inform the development of measurement tools to be used in the second phase.

This paper explores the acceptability of four scenarios of mistreatment during childbirth, as presented to women, midwives and doctors in north central Nigeria. Participants were presented with each scenario and asked if the scenario was acceptable, when (if ever) it would be acceptable, and how they would feel if it happened to them (or their wife or sister in case of a male provider). These four scenarios were developed based on a prioritization activity with the research team to